

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 21 1957

37130

STATE FILE NUMBER

9433

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis,		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis,		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE Alexian Bros. Hosp				Length of stay in lb 24 day		d. STREET ADDRESS 216 W. Stein St. (If outside, give location)	
3. NAME OF DECEASED (Type or print) First CHARLES Middle ELLIS Last AUBUCHON				4. DATE OF DEATH Month Oct. Day 8, Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 19, 1899	
9. AGE (In years last birthday) 58		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maintenance	
11. BIRTHPLACE (City and state or country) St. Louis, Mo.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Ely Aubuchon				14. MOTHER'S MAIDEN NAME Mary Thurman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 496-12-8570		17. INFORMANT Address Olivia Aubuchon, 216 W. Stein St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE-(a) Carcinoma, bladder Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 181x							INTERVAL BETWEEN ONSET AND DEATH 6 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>		SUICIDE <input type="checkbox"/>		HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION St. Louis, Mo.		COUNTY _____ STATE _____	
21. I attended the deceased from 9/15/57 to 10/8/57 and last saw him alive on 10/8/57 Death occurred at 12:10 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE R. M. ... (Degree or title)		22b. ADDRESS 8059 Watson Rd		22c. DATE SIGNED 10/19/57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10/11/57		23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d. LOCATION (City, town, or county) (State) Lemay 23, Mo.	
24. FUNERAL DIRECTOR Fendler Und. Co., 7420 Michigan Ave.				25. DATE RECD. BY LOCAL REG. OCT 9 57		26. REGISTRAR'S SIGNATURE J. Carl Smith Mo	

8059 Watson

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by Student Embalmer No.
working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed

W. G. Peterson

Licensed Embalmer No. *376*

P. O. Address *7420 Michigan*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.